

by the string which had been previously introduced through the fistula. When the tube is in place, the fixation threads are pulled out through the fistula; a short piece of indiarubber drainage-tube is passed over them, so as to keep the fistula from closing, and the strings are tied over a small pad of folded gauze. To prevent the silk thread (which is, as usual, attached to the upper end of the intubation-tube) from being bitten through, it may be brought through the nose by means of Bellocq's sound. [The author describes this excellent proceeding as being quite new, but it is very similar to one recommended by Killian, the apparatus for which is described, we believe, in a catalogue issued by Fischer of Freiburg.—D. G.] Dr. Cuno states that the tube may remain, without damage to the tissues—such as pressure ulcer—for even as long as fourteen days. In cases where intubation, as above described, fails, especially in the so-called “valvular stenosis,” with inward pressure of the upper margin of the tracheal fistula, he recommends a “bolt cannula.” This is introduced through the fistula with its point upwards. It has a large slit through which the patient can breathe, and it can be fixed at different depths by means of a collar similar to that of a tracheotomy-tube. He finds that when this is first introduced there is usually a gradual increased flow of saliva, but at the end of about twenty-four hours the children get quite accustomed to it. [Any contribution towards the treatment of these most difficult cases is gladly welcomed by those whose experience has been at all considerable.—D. G.]

Dundas Grant.

EAR.

Breyre, C.—*A Case of Otitic Pyæmia; Recovery.* “*La Presse Oto-Laryngologique Belge,*” March, 1902.

Mastoiditis supervened in the case of a child, aged seven, with old-standing suppuration of the right middle ear. A fortnight later the usual mastoid operation was performed. The lateral sinus was then found to be very superficial, and only separated from the antrum, which was packed with granulations, by a thin layer of inflamed bone. The sinus itself appeared healthy. The next day the patient had a rigor, followed by oscillations of temperature and abundant and fætid suppuration. This condition continued for nine days. The field of operation was then further explored, and the parts again carefully curetted. After this there was very little discharge and only slight smell, but the tissues remained inactive. Meanwhile, though there was nothing in the state of the wound to account for it, the general condition of the patient gradually became very critical. There was hectic fever, a small and rapid pulse, and total anorexia; also repeated rigors followed by profuse sweats. The spleen was very large. There was no headache or any other cerebral symptom.

Six days after the second operation dulness with deficient respiratory murmur was detected at the base of the right lung. Then followed a troublesome cough with expectoration, at first scanty, but afterwards daily more and more abundant, and eventually very profuse and altogether purulent. The breath became intolerably offensive. At length, a fortnight from the onset of the pulmonary signs, the temperature fell to normal. From this date all the symptoms gradually abated, the wound took on a healthy action, and the patient slowly recovered.

Chichele Nourse.

Randall, M. Alex. (Philadelphia).—*Are there "Variations in the Course of the Facial Nerve having Bearing upon the Mastoid Operation"?* "Arch. of Otol.," vol. xxxii., No. 2.

In contradiction to Schwartze (*vide* JOURNAL OF LARYNGOLOGY, May, 1903, p. 277), Randall states that the descending portion of the facial canal is almost exactly vertical, and forms one of the most constant features of the temporal bone. He arrived at this conclusion by inserting straight probes into the stylo-mastoid foramina of the skull. This cannot be accurately tested in the disarticulated temporal bone, on account of the difficulty of holding it exactly in the position it was occupying in the complete skull. Reference is made to a paper by Seldon Spencer (*Medical Bulletin*, Washington University, April, 1902) containing a diagram indicating that the facial canal is less superficial towards the front of the tympanum than towards the back. Randall found the hiatus Fallopii to be 4 or 8 millimetres nearer the middle line than is the stylo-mastoid foramen, but his measurements showed that the stylo-mastoid foramen is not further out than the downward bend of the facial prominence above the fenestra ovalis. The obliquity is not on the part of the facial nerve, but of the annulus tympanicus, the lower tympanic margin always lying some 3 millimetres internal to the facial nerve at this level. As to the distance of the facial canal posterior to the back wall of the meatus, which is stated by Schwartze to vary from contact to 1 centimetre away, Randall has never found it less than 2 or more than 4 millimetres. [In connection with this subject, we may draw attention to the very interesting and practical topographical relation described by Mr. Hugh Jones of Liverpool at the Liverpool meeting of the Otological Society of the United Kingdom.—D. G.]

Dundas Grant.

REVIEW.

A Text-Book of the Diseases of the Ear for Students and Practitioners.

By Professor ADAM POLITZER, of Vienna, translated at the personal request of the Author and Edited by Milton J. Ballin, Ph.B., M.D., and Clarence L. Heller, M.D. Fourth Edition, revised and enlarged, with 346 original illustrations. London: Baillière, Tindall and Cox. 1902.

The pleasant task of reviewing this, a translation of the fourth edition of Professor Politzer's "Text-book of Diseases of the Ear," has proved rather a longer one than was expected. The new additions are so numerous and so interesting that there is scarcely a page which even an experienced reader of the former editions can afford to skip. The main general features of the work were reviewed with considerable fulness in our issue of October, 1894. We shall therefore content ourselves with saying that the original plan has been strictly followed with few exceptions, it being possible in only very few respects to improve by change a work built on such a solid foundation of experimental, pathological, and clinical observation. As we now again read it we are forcibly struck by how much of what we now look on as the current coin of otology has been the result of the original work of Professor Politzer. We are equally struck by the restless activity he has displayed in studying and appreciating the contributions of others to the advance of otology. He has thus brought his work quite abreast of present-day knowledge, and has rendered it the best all-round *exposé* of all that is worth knowing in this branch of medical science. Among